GRADUATE ASSISTANT CONTINUANTS ONLY

GROUP: **GRADUATE ASSISTANT CONTINUANT** **DUAL-CHOICE** HEALTH INSURANCE APPLICATION

Applicant – Last Name	First	Middle	Social Security Number

Address – Street & No.	City	State	Postal Code	County	Home Telephone Number ( )

Marital Status ☐ Single ☐ Married Date_____ ☐ Divorced Date_____ ☐ Separated Date_____ ☐ Widowed Date_____

Instructions:

To change plans or change to Family coverage, complete all sections of this form in ink. See page H-2 in the Dual-Choice book for more information. If you want to retain your current coverage, do not complete this form.

PLEASE PRINT

Spouse's/Ex-Spouse's Name & Social Security Number

CURRENT GROUP HEALTH INSURANCE PLAN

Plan Name _____

Group No. _____

NEW GROUP HEALTH INSURANCE PLAN SELECTED

Plan Name _____
(*list complete name, including location if part of name*)

COVERAGE DESIRED ☐ Single ☐ Family

OTHER HEALTH INSURANCE COVERAGE (*You must complete this section*)

Are you or a family member insured under Medicare? ☐ No ☐ Yes

If yes, list names of insured and Medicare effective dates.

Name: _____ Dates: Part A _____ Part B _____ Part D _____

Name (spouse):_____ Dates: Part A _____ Part B _____ Part D _____

Are you or a family member insured under another health insurance plan? ☐ No ☐ Yes

If yes, list names of insured and plan.

Name: _____

Name (Spouse): _____

Plan Name (Insurance Co.): _____

Group No.: _____ Subscriber (Policy) No.: _____ Name of Employer:_____

Last Name / First / Middle	Birthdate MO	DAY	YR	Sex M/F	Social Security Number	(see page H-2) Appl. Rel. Code	Student Status	**YOU MUST INDICATE SELECTED PRIMARY PHYSICIAN OR CLINIC and COUNTY** in which located. Indicate **NONE** if electing Standard Plan. PHYSICIAN NAME First & Last	PHYSICIAN'S COUNTY
Applicant						N/A	N/A		
Spouse						N/A	N/A		
Eligible Dependent(s)									

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I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and under the terms and conditions as described on the reverse side of this application. A copy of this application is to be considered as valid as the original. **Submit form with original signature.**

☐ I am a retiree or surviving spouse/dependent ☐ I am on continuation (eligible for a maximum of 36 months' coverage)	DATE SIGNED (MM/DD/CCYY)	APPLICANT SIGNATURE **SIGN HERE**

Return completed form to: Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

Upon receipt and acceptance by ETF, coverage will be **effective 01/01/2006**

FOR DEPARTMENT OF EMPLOYEE TRUST FUNDS USE ONLY

ENROLLMENT TYPE	EMPLOYEE TYPE	COVERAGE CODE	CARRIER SUFFIX	PARTICIPANT'S COUNTY	PROVIDER'S COUNTY
40	13				

EIN	Group Number	ETF Contact Person	Telephone
0000-001	83509		(608)

Monthly Premium	Date Received	COBRA Coverage Expires	Effective Date
$			01/01/2006

TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395.

2. I authorize Employee Trust Funds (ETF) to obtain any information from any source necessary to administer this insurance.

3. I agree to pay in advance the current premium for this insurance and I authorize the remitting agent (i.e., employer) to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to ETF.

4. I understand that eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting my health plan and/or ETF to obtain medical records from health care providers who have treated me, my spouse or any dependents. If medical records are needed, my health plan and/or ETF will provide me with an authorization form.

5. Any children, as defined, listed on this application are unmarried and dependent on me, or the other parent, for at least 50% of support and maintenance. Children may be covered through the end of the year in which they turn 19; or if they are full-time students, coverage continues through the end of the year in which they cease to be a full-time student or turn age 25. Children may also be covered beyond age 19 if they have a disability of long standing duration and are incapable of self-support.

6. I understand it is my responsibility to notify the employer, or if I am an annuitant or continuant to notify ETF, if there is a change affecting my coverage, including but not limited to, a change in eligibility due to divorce or marriage, or an address change due to a residential move. Furthermore, failure to notify the employer may result in loss of coverage, delay in payment of claims and/or loss of continuation rights.

7. I understand that if there is a qualifying event in which a qualified beneficiary (me, my spouse or any dependents) ceases to be covered under this program, the participant(s) may elect to continue group coverage as permitted by state or federal law for a maximum of 36 months from the date of the qualifying event or the date of the notice to my employer, whichever is later. I also understand that if continuation coverage is elected by the affected qualified beneficiary and there is a second qualifying event (i.e, loss of eligibility for coverage due to death, divorce, marriage but not including non-payment of premium) or a change in disability status as determined by the Social Security Administration, continuation coverage, if elected subsequent to the second qualifying event, will not extend beyond the maximum of the initial 36 months of continuation coverage. I understand that notification of these events must be made to ETF in order to take advantage of the maximum 36 months.